ally disappears entirely, leaving the tumor exposed to view.

The x-ray appearance of the exostosis is characteristic. The film shows a bony growth protruding from the end of the phalanx. The size appears smaller in the x-ray than in reality, because the mass is not fully ossified and does not throw the complete shadow picture. The base of the mass may still be cartilaginous and the top covered with fibrous tissue. The x-ray should be resorted to in all cases of persistent pain and tenderness of the distal phalanx, especially if the nail is raised from its bed. Any existing doubt as to the diagnosis will thus be cleared up.

The subungual exostosis is essentially benign, and will not recur after being thoroughly removed, when its matricular substance has been completely destroyed.

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SAFEGUARDED NEEDLE FOR HEMORRHOIDAL INJECTIONS

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THE injection method of treating hemorrhoids is now well established as an ethical and conservative therapeutic procedure.

Various chemical compounds have been used, the most common among them being phenol solutions and the aqueous solutions of quinin and urea hydrochlorid.

In simplifying the technique for the injection method of treating internal hemorrhoids, four essential procedures are necessary: (1) easy presentation of the hemorrhoidal mass; (2) adequate asepsis at the point of puncture; (3) the least possible traumatization of the mucosa at the point of introduction of the needle, with a definite stop to prevent too deep introduction of the needle; (4) and a chemical preparation which will give the quickest and most permanent reactionary effect, with complete reduction of the hemorrhoidal mass without sloughing.

The internal hemorrhoidal mass can be easily presented for inspection and treatment with Hirshman's anascope, exposing a quadrant of the lower rectal zone with the hemorrhoid in view, if one is present. The anascope can be easily rotated to present that region of the lower rectum having the hemorrhoidal mass, so that the mass bulges into the lumen of the anascope over the proximal edge of the oblique aperture in good position for the injection.

In order to obtain an aseptic field for the introduction of the needle, it is best to have the usual cleansing enema prior to the examination; and then, just preceding the introduction of the needle, the hemorrhoidal mass should be thoroughly swabbed with cresitin, or some other local antiseptic solution, and a definite application of a stronger antiseptic solution made at the point of puncture.

In order to cause the least traumatization of the mucosa which already has been more or less abraded and eroded, especially where there has been frequent bleeding from the hemorrhoid, a very small needle should be used, not over a 25 gauge. To avoid thrusting the needle too far into the hemorrhoidal mass, a safety-stop needle, similar to the illustration (Fig. 1), should be used.

Fig. 1.—A Safeguarded Needle for Hemorrhoidal Injection.

This needle has a metal bead welded to the shaft, one-fourth, three-eighths, or one-half inch from its end. The length of the needle should be at least one and one-half inches long. The aperture of the needle should be very obliquely beveled.

The needle should be plunged through the mucosa in a diagonal manner, prior to the injection of the sclerosing solution.

The point of injection of the hemorrhoid depends a great deal upon the size, extent and structural condition of the mass. The amount of solution to be injected also depends upon these factors. Five to ten minims of the 4 per cent aqueous solution of quinin hydrochlorid is usually sufficient to produce the necessary reaction to obliterate the hemorrhoidal mass. The best reactionary effect seems to be a sclerosis of the mucosa and submucosa, causing an indurated mass which gradually becomes absorbed and obliterated.

Immediate compression of the hemorrhoidal mass for about ten minutes with a firm, large cotton applicator, after the needle has been withdrawn, will diminish the amount and extent of the reactionary induration without interfering with the end-result. After the induration is absorbed, the rectal mucosa has a firm and elastic consistency, and is firmly adherent to the muscular coat.

The abnormal distention of the hemorrhoidal veins, arterioles and the venous lakes in the submucosa become completely reduced following this technique, and the induration becomes absorbed. Protrusion and ectropion of any residual hemorrhoidal mass is permanently prevented by the plastic infiltration which takes place between the mucous and muscular coats above the pectinate line.

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The Way He Walks.—I need not describe to you in detail here the stamping, broad-based action of tabes dorsalis; the steppage, drop-foot gait of peripheral neuritis; the dragging spastic gait of the paraplegic and the hemiplegic; the festinant trot of the paralysis agitans; or the stiffening shuffle of old age. Their enumeration, however, brings me to the question of how we may best train our eyes to do better as time goes by. I would first of all tell you simply to make a rule of having a good look at every patient as he walks into your presence or sits or stands or lies before you. To avoid embarrassment ask a question or two by all means, but study him well meanwhile. The art of medicine is largely the art of noticing. You need to cultivate constantly both the enthusiasm and the watchful patience of the field naturalist if you wish to obtain the full value and interest which clinical work can bring.—Ryle, J. A.: The Training and Use of the Senses in Clinical Work, *Guy's Hospital Gazette*, 47:421 (Oct. 28), 1933.